STATE OF MAINE
BOARD OF NURSING
158 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0158

JOHN ELIAS BALDACCI
GOVERNOR

MYRA A. BROADWAY, J.D., M.S., R.N.
EXECUTIVE DIRECTOR

VERIFICATION FORM

TO BE COMPLETED BY APPLICANT:

Name of Applicant: _____

Present Address: _____

Maine RN License Number: _____

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TO BE COMPLETED BY CERTIFYING BODY AND RETURNED DIRECTLY TO THE BOARD.

1. Eligible to take certification examination? **Yes**_____ **No**_____
   Date certification examination scheduled: _____

2. Results of certification examination: _____
   Initial certification date:_____ Date certification expires: _____
   Certified as a(n)_____
   (Speciality)
   by_____
   (Name of Certifying Body)

3. Eligible for recertification? **Yes**_____ **No**_____
   If **No** please explain:_____
   _____
   Recertification date: _____ Date recertification expires: _____
   Has the applicant been granted a provisional or conditional recertification? **Yes**____ **No**_____
   If **Yes** please explain: _____
   _____

NAME: _____

TITLE: _____

DATE: _____

SEAL